



**Pierce County Junior Wrestling League and
City of Auburn, Parks, Arts and Recreation Medical Waiver**

Wrestler's Name: _____ Date of Birth _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
School: _____ Grade _____ Weight: _____
Allergies: _____ Drug sensitivities: _____
Is child presently on medication? **Yes No** List Medications: _____
Notes: _____

Doctor's Name: _____ Phone: () _____

Name of Insured Person _____ Insurance Company _____

Place of Employment _____ Phone _____

Mom's Name: _____ Email _____

Home phone: () _____ Work phone: () _____ Cell phone (emergency): () _____

Dad's Name: _____ Email _____

Home phone: () _____ Work phone: () _____ Cell phone (emergency): () _____

Emergency Contact: _____

Home phone: () _____ Work phone: () _____ Cell phone (emergency): () _____

HOLD HARMLESS AND INDEMNITY AGREEMENT

*I, Parent or Guardian of the above named child, hereby give my consent to such child's participation in the authorized activities of the **City of Auburn** Junior Wrestling Program. I understand that wrestling is an activity which involves bodily contact and that occasionally participants suffer some injuries. In consideration of the organization's permitting my child to participate in its programs, I agree to hold it, its coaches, officers or referees harmless from any claims for personal injuries that may result to the above named child in the course of his/her participating in the organization's activities, and to indemnify it in the event it is compelled to pay any claim thereon.*

*I, Parent or Guardian of the above named child, agree to provide or arrange transportation for my wrestler to all wrestling matches/tournaments, and to release the **City of Auburn** Junior Wrestling organization from any responsibility for my child during transportation.*

Signature of Parent/Guardian _____ **Date:** _____

PARENTAL INSTRUCTIONS CONCERNING MEDICAL TREATMENT

Please read the 2 statements below and **sign ONLY the 1** that you choose.

1. If my child needs medical attention, it is my wish that I be contacted before any medical procedures are done on my child unless immediate treatment is necessary to save my child's life or to prevent permanent damage. **I accept responsibility for all costs related to such treatments.**

Signature of Parent/Guardian _____ **Date:** _____

OR

2. If my child needs medical treatment while participating, it is my wish that treatment begin while efforts are being made to contact me. **I accept responsibility for all costs related to such treatments.**

Signature of Parent/Guardian _____ **Date:** _____